

PLASTIC SURGERY ASSOCIATES

Patient Information Form- please print

Patient Name _____ Date of Birth _____ age _____
 Address _____ Home phone# _____
 City _____ State _____ Zip _____ Cell Phone# _____
 Email address _____ Marital status M S W D Gender M F
 Primary Language _____ Driver's License# _____ Social Security# _____
 Employer _____ Occupation _____ Full Time/ Part Time
 Address _____
 Business Phone# _____ May we contact you at work? Yes No
 Spouse's Name _____ Date of Birth _____ Social Security# _____
 Employer _____ Employer Phone# _____
 Next of Kin/ Emergency Contact _____ Phone# _____
 Primary Care Physician _____ Phone# _____

How did you hear about our office? _____
 Please indicate if there is anything we need to know to provide you more personal care _____

YOU WILL NEED TO PRESENT YOUR INSURANCE CARD AT THE TIME OF YOUR APPOINTMENT

Is this a Worker's Compensation or Auto Accident? Yes No
 Insurance Company _____ claim# _____
 Address _____ phone# _____

ASSIGNMENT OF BENEFITS, INSURANCE BILLING AUTHORIZATION, RECORDS RELEASE

I hereby authorize my insurance benefits to be paid directly to the provider who rendered my services. I realize I am responsible for paying deductibles, copays, any non-covered services, and/or any services disputed by my insurance company, as well as any collection fees. I hereby authorize the release of pertinent medical information necessary to process my claim, which may include mental, physical, prescription, substance abuse, communicable diseases and infections, HIV-related, AIDS, or AIDS related information. I further authorize release of the described pertinent information to other medical providers involved in my care.

_____ (patient/parent/guardian signature) _____ (date)
 _____ (witness signature) _____ (date)

I Have Received a Copy of the Notice of Privacy Practices at Plastic Surgery Associates, patient rights and responsibilities, and the disclosure of ownership.

What is your main concern(s) for today's discussion? _____

If injury, what was the date of the injury? _____ Were X-Rays taken? Yes No Where? _____

Have you consulted any other physician for this problem? No Yes- who? _____

Do you have an advanced directive? ___yes ___no If no, you can find information at www.michigan.gov/mdhhs.

*If **YES**, please bring a copy with you on the day of surgery.

Allergies/reaction: _____

Medications(prescription): name, dose, frequency, reason

Over the Counter(herbal supplements/vitamins):

Surgeries/Hospitalizations:

_____ date _____
_____ date _____
_____ date _____
_____ date _____

Anesthesia History:

Have you had anesthesia? Yes No
Nausea/Vomiting after? Yes No
Motion Sickness? Yes No
Malignant Hyperthermia?
(self or family) Yes No

Female patients:

Number of Pregnancies _____
Number of Children _____
Most Recent Mammogram _____
Location of Mammogram _____

Social History:

(please indicate daily consumption):
Alcohol _____
Tobacco or Tobacco Products _____
Other intoxicating substances _____

Height _____ How much weight have you **lost** in the past year? _____

Weight _____ How much weight have you **gained** in the past year? _____

Past Medical History								
	yes	no		yes	no		yes	no
Eye Injury			Heart Disease			Diabetes		
Eye Disease			Heart Attack			Thyroid Disorder		
Dry Eye			High Blood Pressure			Numbness of hands/feet		
Impaired Vision			Blood Clots			MRSA		
Blackouts			Bleeding Tendency			TB		
Seizures			Rheumatic Fever			Hepatitis		
Concussion/Head Injury			Cancer			AIDS/HIV		
Facial Nerve Injury			Asthma			AutoImmune Disease		
Wide Scars			Chronic Cough			Gonorrhea		
Keloids			Respiratory Problems			Syphilis		
Gastric Surgery			Pneumonia			Mental Illness		
			Sleep Apnea			Depression/Anxiety		

I realize that accurate medical information is essential for safe and proper medical care. The above information is true and accurate to my best knowledge.

(patient signature)

(date)

(patient signature)

(date)